

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. \_\_\_\_\_  
Registrar's No. **3220**

**ED MAY 15 1940 791**

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St Louis  
(c) Name of hospital or institution: Homer G Phillios  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 das  
In this community Unknown (Specify whether years, months or days)

3. (a) PRINT FULL NAME Shirley Mae Brown **650**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race NEGR 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife If alive \_\_\_\_\_ years  
7. Birth date of deceased April 29th 1939  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 11 6 hr. min.

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business None

12. Name SPENCER BROWN

13. Birthplace Mississippi  
(City, town, or county) (State or foreign country)

14. Maiden name Willie Mae Williams  
(City, town, or county) (State or foreign country)

15. Birthplace ARK.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Spencer Brown

(b) Address 2207 1/2 Delmar Blvd

17. (a) (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof 4-10-1940  
(Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Atkins Bros

(b) Address 3644 Finney Ave

19. (a) APR 10 1940  
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St Louis **21**  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2207 1/2 Delmar  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5  
year 1940 hour 8:30 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from March 28, 1940, to April 5, 1940,  
that I last saw h. er alive on April 5, 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia (primary) Duration 2 wks

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 107a  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy Bronchopneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature L. E. Peace (M. D. or other) \_\_\_\_\_

Address 2601 N Whittier Date signed \_\_\_\_\_

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *Lorris V. Atkins*

Licensed Embalmer No. *2842*

P. O. Address *3644 Finney*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**